State of Louisiana

Department of Health and Hospitals
Office of Aging and Adult Services

Release of Confidentiality for Shared Personal Assistance Services

Participant's Name:			
SSN:		**DOB:**	

I am requesting that shared personal assistance services be included in my Plan of Care in order to participate in shared Personal Assistance Services.

In addition, I give permission for my name to be used in the Plan of Care, progress notes, individualized service plan, etc. of the other individuals.

I understand that my permission to release this information may be canceled at any time, except when information has already been released.

_____ _____
Participant's Signature Date

_____ _____
Support Coordinator's Signature Date

_____ _____
Direct Service Provider's Signature Date

The following signatures are <u>only</u> needed if the participant signs his/her name with an "X".

_____ _____
Witness' Signature Date

_____ _____
Witness' Signature Date